



## MONTANA STATE PRISON HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS I-01.0	Subject: <b>Mental Health Observation &amp; Clinical Restraints in the Infirmary &amp; Locked Housing Units</b>	
Effective Date: 6-20-12	Revised: 6-1-17	Page 1 of 12 and five attachments
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### **I. Purpose:**

To establish policy and procedures governing the use of Mental Health Observation & Clinical Restraints which are to be used only when an inmate is in imminent risk of significant violence or self-destructive behavior that may cause permanent bodily damage/harm or death to themselves or others. To ensure all other less restrictive intervention has been attempted prior to utilization of restraints. To ensure Mental Health Observation & Clinical Restraint procedures are used in accordance with state law and federal regulations. To define the difference between custody and clinical restraints. To provide guidelines for implementation of written and enforceable therapeutic procedures, and establishing responsibilities for the systemic review and monitoring of compliance.

### **II. Definitions:**

Infirmary Observation - two levels of inmate observation (Level 1 and Level 2. Observation) are provided in the infirmary in rooms South Isolation 7 (SI 7) and South Isolation 6 (SI 6). Infirmary observation is not an alternative to disciplinary segregation, nor is it to be confused with Behavior Management Plans (see MSP 3.5.5). Infirmary observation is not seclusion because the cells are not isolated from the infirmary, are within the infirmary, and are readily accessible to health care personnel. Health care personnel are within visual and auditory reach of the infirmary observation cells at all times.

Level 1 Observation – more restrictive of the two infirmary observation levels. Level 1 is reserved for inmates who are actively suicidal, either threatening or engaging in suicidal behavior. Level 1 Observation is used when an inmate is agitated, threatening, or poses an imminent risk of harm to self or others, and the use of the locked housing unit isolation cell is not indicated. Generally Level 1 Observation inmates will be observed by staff at least every 15 minutes via the video monitor, and at least every 30 minutes face to face. Property and clothing restrictions are standardized: one safety blanket and mattress OR one safety blanket with attached pillow; one safety vest; no sharps; food loaf only; no other clothing; and no personal property items. Inmates who are acutely suicidal will be placed on 1:1 constant observation.

Level 2 Observation – the least restrictive of the two infirmary observation levels. Level 2 is reserved for inmates that are not actively suicidal but expresses suicide ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have psychiatric symptoms that need to be observed closely and documented). Inmates may also be placed in Level 2 Observation if they need to be separated from the general population of the prison for short periods of time to regain self-control over disruptive or disturbing behaviors that interfere with their ability to function in the prison environment, and/or the inmate needs a brief “time out” due to stressful events or altercations with other inmates or staff. Generally Level 2 Observation inmates will be observed by staff at least every 15 minutes via the video monitor and at least every 60 minutes face to face. Inmates will usually have infirmary issued clothing. Property and meals will vary and will be ordered by mental health professional staff according to the inmate’s risk level.

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Clinical restraints - the use of any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces free movement of an inmate's arms, legs, or body, that are ordered by qualified mental health professional staff. Approved clinical restraints are located in the main infirmary shadow box. The restraint chair and shadow box key are located in the Command Post. The level of restraint used may vary according to the Psychiatrist/Physician's order and clinical judgment. At a minimum, the patient is to be restrained at the waist and one ankle. Additional limbs (other ankle, wrists or shoulders) may also be restrained if necessary. The following terms will be used when ordering restraints:

Restraint Chair(5 points): refers to the placement in an authorized chair designed for the purpose of restraint. The chair is designed to secure ankles, wrists and torso in an upright sitting position.

Full soft restraints (5 points): refers to the placement of a patient on a bed with restraints applied to the waist, each ankle, and each wrist.

Three point restraints: refers to the placement of a patient on a bed with restraints applied to the waist and both ankles.

Two point restraints: refers to the placement of a patient on a bed with restraints applied to either both wrists or both ankles.

All restraints, with the exclusion of the restraint chair, will be securely fastened to the frame of the bed in the infirmary South Isolation room 6. All buckles and protrusions from restraint devices will be padded or located so that they do not rub against the inmate's body. Inmates are not to be restrained in a way that would jeopardize their health. Any time that any form of bed restraint is used for behavioral interventions, the room must be locked when a staff member is not present in order to prevent the entry of unauthorized persons.

If the restraint chair is authorized it may be applied in South Isolation room 7 in the main infirmary or in Locked Housing Unit Isolation cells at the Psychiatrist/Physicians order/discretion.

Other clinical restraints - occasionally it is necessary to use other restraint procedures such as a helmet to prevent head injury. In such a case, the Psychiatrist/Physician's order must specifically designate the procedure to be carried out, and a progress note must be written by the Psychiatrist/Physician providing the rationale for the action taken. All documentation and care procedures will be completed in the same manner used for other restraint procedures.

Custody restraints - per *MSP 3.1.8, Use of Force & Restraints*, mechanical restraints are: devices such as restraint chairs, flex cuffs, hand cuffs, belly chains, and leg irons. Soft restraints: restraints made of leather, nylon, canvas, or other soft material.

Location of inmates in Infirmary Observation or Clinical Restraints - MSP infirmary, usually within cells South Isolation 7 and South Isolation 6. Observation cells without cameras include South Isolation 5 and all North Isolation cells, these cells may be used as clinically indicated.

Clinical assessment for the use of Infirmary Observation and Clinical Restraints - an assessment in which a qualified mental health professional and Psychiatrist/Physician substantiates, through documentation in the medical record, the reason observation/restraint is necessary to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the inmate or staff and other less restrictive means are not feasible.

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Criteria/clinical justification for Infirmary Observation and Clinical Restraints: to prevent the inmate from imminent risk of significant violence or self-destructive behavior to others or themselves when less restrictive interventions are inadequate to prevent the behavior.

Emergency: a situation in which action is necessary to prevent an imminent risk of significant violence or self-destructive behavior to others, and/or self.

Qualified mental health professional staff - includes psychiatrists, psychologists, psychiatric nurses, licensed clinical social workers, licensed clinical professional counselors, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of the patients.

### III. Procedure:

#### A. General

1. Mentally ill and medically ill inmates will be free from physical restraint and seclusion except for emergency situations in which there is an imminent risk that inmates could harm themselves or others and other means to control the behavior is not feasible or has failed.
2. Infirmary observation and restraints are emergency procedures used only to prevent inmates from harming others or oneself as a result of medical and/or mental illness.
3. Qualified mental health professional staff have the final authority to continue clinical restraint of inmates ordered by custody staff (*MSP 3.1.8, Use of Force & Restraints*).
4. Clinical restraints will only be implemented and utilized under the direction and supervision of qualified mental health professional staff. If the qualified mental health professionals do not agree with the decision of custody staff to restrain an inmate, other than with mechanical restraints, clinical restraints will not be used.
  - a. When a restrained inmate develops a medical or mental health condition during a restraint ordered by custody staff, the physician is notified immediately so appropriate order are given
  - b. Improper use of restraints that jeopardizes the health of an inmate are reported immediately to appropriate custody staff
  - c. Except for monitoring of health and mental health status, health care staff do not participate in the restraint of an inmate ordered by custody staff.
5. With regard to custody-ordered restraints:
  - a. When restraints are used by custody staff for security reasons, health services staff are notified immediately in order to:
    - i. Review the health record for any medical and mental health contraindications or accommodations required, which, if present, are immediately communicated to appropriate custody staff.
    - ii. Initiate health monitoring, which continues at designated intervals as long as the inmate is restrained. If the health of the inmate is at risk, it is immediately communicated to appropriate custody staff.
6. Infirmary observation and restraints are not treatment, and may not be implemented as a behavior consequence in response to a previously occurring behavior, or imposed as a means of harassment, punishment, coercion, discipline, convenience, or retaliation by staff.

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7. Infirmary observation and restraint procedures may only be used when clinically justified in accordance with the Psychiatrist/Physician's order and used only when less restrictive interventions have been determined to be ineffective. The type of infirmary observation or restraint must be the least restrictive procedure to effectively protect the inmate, staff, or others from harm. Infirmary observation and restraint procedures must end at the earliest possible time.
  8. The restraint chair may only be utilized as a clinical restraint under these specific parameters:
    - a. Clear documented history that the offender does not have a serious disabling mental illness
    - b. Clear documentation that the offender has a history of being uncontrolled by less restrictive means as well as other clinical restraint methods
    - c. Clearly documented history as being a danger to himself or others while in less restrictive mechanical or clinical restraints
  9. Orders for the use of Infirmary observation and restraint are never written as a standing order or on an as needed basis (PRN).
  10. When Infirmary observation and restraint procedures are implemented, the inmate must be assessed face to face by a Psychiatrist/Physician within the required time periods, and by a qualified mental health professional within the required time periods
  11. When clinical restraints are implemented, a correctional officer will be stationed outside of the inmate's door to provide one-on-one observation. The correctional officer will document the inmate's status every 15 minutes and alert infirmary staff to any problems that may occur.
- B. Non-licensed infirmary staff and security staff general procedures:
1. Non-licensed infirmary staff and security staff will promptly inform licensed nursing staff about any changes in an inmate's behavior or condition.
  2. Security Staff will apply clinical chair restraints only under the supervision of qualified medical/mental health professionals.
  3. Non-licensed infirmary staff and security staff will seek direction from licensed nursing staff, qualified mental health professionals, and appropriate security staff when direct care staff has questions about whether the level of restrictions placed upon the inmate should be increased or decreased.
  4. Non-licensed infirmary staff and security staff will complete an incident report whenever any adverse outcome occurs (falls, injuries, or allegation of abuse) as a result of the procedure.
  5. Non-licensed infirmary staff and security staff will follow orders given by the mental health professional staff on the *Infirmary Observation and Management Plan* or the *Infirmary Clinical Restraints and Treatment Plan (Attachments # 1 and # 2)*.
    - a. **Non-licensed infirmary staff procedures for Infirmary Observation:**
      - 1) Assist in providing necessary care to the inmate as directed by a psychiatrist/physician, licensed nurse, or qualified mental health professional.
      - 2) Provide the level of required observation and restrictions as ordered by the mental health professional or psychiatrist/physician.
    - b. **Non –licensed infirmary staff procedures for Clinical Restraints.**

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- 1) Closely monitor the inmate in restraints and make adjustments as necessary in order to insure that the inmate is as physically comfortable as possible while restrained. No restraint or body positioning of the inmate shall place excessive pressure on the chest or back of the inmate or inhibit or impede the patient's ability to breathe. Inmates are to be restrained in a manner to minimize potential medical complications.
- 2) Assist in providing necessary care to the inmate as directed by a psychiatrist/physician, licensed nurse, or qualified mental health professional.
- 3) Change the inmate's linen, bedding, and clothing promptly as it becomes soiled.
- 4) Offer fluids at least every two hours or more frequently if the inmate is dehydrated, unless fluids are restricted by a physician's order. Meals and snacks will be offered at regular intervals.
- 5) Offer the patient use of the toilet facilities or a bedpan/urinal at least hourly, and whenever an inmate requests the need.
- 6) Allow and/or assist patients to bathe or shower at least daily when procedures are used for an extended period of time. When necessary, a bed bath may be given. Inmates will be provided am and hs care including oral care, washing of face, hands, hair care, and other care and comfort measures as appropriate. Staff will prompt and assist the patient to wash hands before meals and after toileting.

C. Licensed Infirmery staff general procedures

1. Licensed Infirmery staff will obtain verbal or written order from the psychiatrist/physician for the procedure prior to implementation or as soon as possible after an emergency implementation of Infirmery observation or clinical restraints and document the order in the medical record. The order will include the level of observation, type of clinical restraints, clinical rationale for use of the procedure, and behavior criteria the inmate must meet to release/remove from infirmery observation or clinical restraints.

a. **Licensed Infirmery staff procedures for an inmate in Infirmery Observation Level 1:**

- 1) The on-call qualified mental health professional will communicate their desire to place an inmate in infirmery observation Level 1. They will report the rationale, restrictions, and criteria for release. After receiving this information, then:
- 2) Notify the psychiatrist/physician within one hour of an inmate being placed in Level 1 observation, and write the order to admit to the infirmery with restrictions, rationale, and criteria for release in the medical record.
- 3) Explain all steps of the intervention to the inmate, including why intervention is necessary, and criteria for termination of the Level 1 observation.
- 4) Document all behaviors and interactions with the inmate in the medical record on the Nursing Notes/Assessment Flow Sheet and on the *Monitoring Checklist for Level 1 or 2 Observation (attachment # 3)*.

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- 5) Document all care rendered to an inmate, e.g., hygiene, diet, fluid, intake, bowel/bladder functions, physical observations, and vital signs (when ordered) Nursing Notes/Assessment Flow Sheet.
- 6) Provide video and in-person observation as ordered by the qualified mental health professional and the psychiatrist/physician.
- 7) Insure proper documentation by non-licensed infirmery staff.
- 8) Direct the reduction of the level of restrictions or termination of the intervention when the criteria set by the qualified mental health professional or the psychiatrist/physician has been met or the inmate demonstrates a decreased risk of imminent danger to himself or others.
- 9) Obtain additional psychiatrist/physician orders should an increased level of intervention become necessary (e.g., change in placement of the inmate from Level 1 observation to clinical restraints).
- 10) Obtain psychiatrist/physician orders to discontinue the intervention and discharge from the infirmery.

**b. Licensed Infirmery staff procedures for an inmate in Infirmery Observation Level 2:**

- 1) The on-call qualified mental health professional will communicate their desire to place an inmate in infirmery observation Level 2. They will report the rationale, restrictions, and criteria for release. After receiving this information, then:
- 2) Notify the psychiatrist/physician within one hour of an inmate being placed in infirmery observation Level 2, and write the order designating the restrictions, rationale, and criteria for release in the medical record.
- 3) Explain all steps of the intervention to the inmate including why intervention is necessary and criteria for termination of infirmery observation Level 2.
- 4) Document all behaviors and interactions with the inmate in the medical record Nursing Notes/Assessment Flow Sheet and on the *Monitoring Checklist for Level 1 or Level 2 Observation (attachment # 3) if ordered.*
- 5) Document all care rendered to an inmate, e.g., hygiene, diet, fluid, intake, bowel/bladder functions, physical observations, and vital signs (when ordered) on Nursing Notes/Assessment Flow Sheet.
- 6) Insure proper documentation by non-licensed infirmery staff.
- 7) Direct the reduction of the level of restrictions or termination of the intervention when the criteria set by the qualified mental health professional or the psychiatrist/physician has been met or the inmate demonstrates a decreased risk of imminent danger to himself or others.
- 8) Obtain additional psychiatrist/physician orders should an increased level of intervention become necessary (e.g., change in placement of the inmate from Level 2 observation to Level 1 observation).
- 9) Obtain psychiatrist/physician orders to discontinue the intervention and discharge from the infirmery.

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- c. **Licensed Infirmary staff procedures for an inmate in Clinical Restraints:** *(all procedures below will be followed in both Infirmary and Locked Housing Units I & II).*
- 1) The psychiatrist/physician or the on call qualified mental health professional will ask you to place an inmate in clinical restraints and report the rationale, type of restraint, and criteria for release, then:
  - 2) Notify the psychiatrist/physician within one hour of an inmate being placed in clinical restraints and write the order with the type of restraint (e.g., full restraints), restrictions, rationale, and criteria for release in the medical record.
  - 3) Restraint orders are valid for a maximum of 24 hours. If procedures are continued, orders must be renewed by the psychiatrist/physician every 24 hours.
  - 4) Face to face evaluation of an inmate in restraints by a psychiatrist or physician must occur every 24 hours before writing a new order for the continued use of restraints. The psychiatrist/physician visit must be documented by nursing staff on the Nursing Assessment Flowsheet.
  - 5) Explain all steps of the intervention to the inmate including why the intervention is necessary and criteria for termination of the intervention. This is documented in the medical record on the Nursing Assessment Flowsheet.
  - 6) Ensure that proper documentation and reporting procedures have been completed by other infirmary and security staff involved in the procedure.
  - 7) Provide constant video observation when the correctional officer stationed at the cell door for one-on-one observation is on break. Provide face-to-face observation every 15 minutes for restraints used in the Infirmary.
  - 8) Monitor vital signs every two hours or more often as directed. In the event the inmate's behavior renders this impossible or unsafe for either the inmate or the staff, this will be documented in the medical record on the Nursing Assessment Flowsheet.
  - 9) Provide the inmate with an opportunity for range-of-motion (ROM) exercise to both the upper and lower extremities for at least 10 minutes every two hours, unless the inmate's behavior renders this impossible or unsafe for either the patient or staff, or it is contraindicated by condition of the joint or limb, or the inmate is asleep. Document ROM in the medical record on the Nursing Assessment Graphic Record.
  - 10) Assess the inmate's respirations for irregular, gasping, or gurgling breath sounds. Assess for skin color changes, changes in the color of the nail beds or lips, bulging neck veins, and inappropriate vital signs. Notify the psychiatrist/physician of abnormal results.
  - 11) Document on the *Monitoring Checklist for Clinical Restraints form (attachment # 4)* every 15 minutes while clinical restraints are being utilized in the infirmary and every 2 hours while clinical restraints are being utilized in Locked Housing Units I and II.
  - 12) Document in the medical record on the Nursing Assessment Flowsheet: inmate's behavior, physical condition, care provided including hygiene,

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diet, fluid intake, bowel/bladder functions, physical observations, range-of-motion, vital signs, and any exceptions to care with reason/rationale at least once a shift.

- 13) Notify the psychiatrist/physician when renewal of the restraint order is needed.
- 14) Notify the on-call qualified mental health professional if any changes occur in the inmate's behavior, or if changes are needed in the management plan.
- 15) Obtain additional psychiatrist/physician orders should an increased level of intervention become necessary (e.g., any modification that increases the level of restraint).
- 16) Supervise and assist staff with the safe implementation of clinical restraints.
- 17) Direct the reduction of the level of clinical restraints and the termination of the procedure when the criteria for release is met as set by the psychiatrist/physician and the patient is no longer an imminent risk of significant violence or self-destructive behavior.

D. Qualified Mental Health Professional staff general procedures:

1. Will respond promptly when requested to assist with an intervention or to check an inmate that has been placed in infirmery observation or clinical restraints. Will document each emergency assessment on the *Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan form (attachment # 5)*.
2. Respond by phone within one hour regarding an inmate placed in infirmery observation or clinical restraints and assist the infirmery staff with establishing adequate Infirmery mental health treatment planning and interventions.
3. Document and discuss the *Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachment # 5)* with the psychiatrist/physician, or the mental health director, or the clinical psychologist if the inmate remains in the infirmery after three working days.
4. Promptly review with the psychiatrist/physician any significant changes in the inmate's condition, status, or management plan.
5. Assist in processing the incident with the inmate and staff.
6. Notify the receiving housing unit that an inmate is being discharged back to them, give them a summary of the outcome of the intervention, and assist staff with any concerns that may arise.
  - a. **Qualified Mental Health Professional staff procedures for an inmate in Infirmery Observation, Level 1, and Level 2:**
    - 1) Consult with the Licensed Infirmery staff and ask them to place an inmate in Infirmery observation, Level 1 or 2, and give them rationale, modifications to the standard admission orders, criteria for release, and what they need to observe and document.
    - 2) Will see an inmate face-to-face who was placed in Infirmery observation, Level 1 or 2, within 12 hours of his admission to assess the current status of behaviors and symptoms and signs of psychological trauma



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- 3) At the time that the inmate is seen face-to-face will document on the *Infirmery Observation and Management Plan (attachment # 1)* and the *Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachments #5)*.
  - 4) Ensure that the level of intervention is reduced per the criteria set in the form: *Emergency Mental Health Evaluation, Suicide Risk Assessment and Treatment Plan (attachment #5)* are met or when the inmate demonstrates a decreased risk to self or others.
  - 5) Document and update forms: *Infirmery Observation and Management Plan (attachment #1)* and the *Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachment #5)* each time a patient is assessed in the infirmery.
  - 6) Monitor the use of Infirmery observation at least every 24 hours by telephone on weekends and holidays or at least every 24 hours face-to-face during regular working hours as long as the intervention continues. Document interaction and communication with infirmery staff and the condition of the inmate on forms: *Infirmery Observation and Management Plan (attachment # 1)* and the *Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachment #5)*.
  - 7) When an inmate is discharged from the infirmery, documentation of the interaction and communication with the unit where the inmate will discharge to will be done on the *Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachment #5)* along with the name of the staff person that the case was discussed and follow-up plans for mental health services.
  - 9) All documentation will be copied for both the medical file and mental health clinic file.
- b. **Qualified Mental Health staff procedures for an inmate in Clinical Restraints:**
- 1) Consult with the Licensed Infirmery staff and ask them to place an inmate in clinical restraints with rationale, restrictions, visual checks, and criteria for release.
  - 2) Assess the inmate within three hours of placement in clinical restraints unless the psychiatrist/physician has already done so. If the psychiatrist/physician justified the patient within three hours, the on-call mental health professional will assess the inmate within 12 hours and justify the use of restraints. Justification of restraints must occur during this assessment.
  - 3) Provide the inmate with a clear explanation of the reason for clinical restraints, the monitoring procedure, the desired outcome, and the criteria the inmate must meet in order for the procedure to be discontinued.
  - 4) Documentation of justification for restraints must be done at the time that the inmate is initially seen by the on-call mental health professional using the *Infirmery Clinical Restraints and Treatment Plan(attachment # 2)* and the *Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachment # 5)*.

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- 5) Document and update forms: *Infirmary Clinical Restraints and Treatment Plan and Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachments # 2 and # 5)* each time a patient is assessed after the initial assessment. Documentation will include the inmate's behavior when seen by the mental health professional, continued justification for the intervention, and specify behavior that will allow termination of the intervention.
- 6) Monitor the use of clinical restraints at least every 24 hours by telephone on weekends and holidays or by face-to-face interview on regular work days (in accordance with appropriate clinical judgment) as long as the intervention continues. Document that you talked with the infirmary staff, the condition of the inmate, and your plans for seeing the inmate next on forms: *Infirmary Clinical Restraints and Treatment Plan and the Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachments # 2 and # 5)*.
- 7) Consult with the psychiatrist/physician each day that the inmate remains in restraints. Document the results of the consult. Consultation with the physician/psychiatrist during weekends and holidays may occur via the Infirmary staff.
- 8) When an inmate is discharged from the Infirmary, documentation of the interaction and communication with the unit where the inmate will discharge will be done on the *Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan (attachment # 5)* along with the name(s) of the staff person that the case was discussed and follow-up plans for mental health services.
- 9) All documentation will be copied for both the medical file and mental health clinic file.

E. Psychiatrist or Physician general procedures:

1. To provide verbal or written orders within one hour for the use of Infirmary Observation or Clinical Restraints, and to insure that all procedures carried out are consistent with these orders, the orders must clearly state:
  - a. the reason or justification for the procedure;
  - b. the specific type of procedure to be used;
  - c. the maximum time period allowed for the procedure;
  - d. the criteria for release; and
  - e. the date and time.
2. Orders for Infirmary Observation are valid for the entire infirmary stay. Orders for Clinical Restraint need to be renewed every 24 hours.
3. To provide verbal or written orders to discharge from Infirmary Observation or from Clinical Restraints.
4. To direct staff members at all levels in the provision of care and treatment of inmates for whom Infirmary Observation or Clinical Restraint interventions are used.
5. To order changes in the inmate's treatment program which are intended to reduce reliance on Infirmary Observation or Clinical Restraints.

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6. To provide assistance by phone or in person, if requested, for the mental health professional on call and for the licensed infirmary staff.
7. To perform a face-to-face examination of an inmate placed in restraints within 24 hours after initiation of the intervention.
8. To re-examine an inmate placed in restraints at least every 24 hours and provide a written order for the continuation of restraints. This order should justify continued use of the intervention, the specific type of intervention to be used, and the criteria for release.
9. To enter a progress note in the inmate's medical record each time an inmate in Infirmary Observation or Clinical Restraints is examined. Documentation must address the inmate's medical and psychiatric condition and needs, the episode requiring intervention, and a plan for continuing care including need to continue or terminate the procedure. Copies of the progress note will be placed in the medical chart and the mental health clinic file.

F. Mental Health Services Manager general procedures:

1. Will be available for consultation and review of the procedures.
2. Will ensure the review of the use of Clinical Restraints as indicated.
3. Will ensure that appropriate staff are trained in the application and removal of Clinical Restraints.

G. Responsibilities:

1. Staff who have received facility approved training in safe management of therapeutic restraint application may participate in physically restraining inmates. All staff shall make efforts to preserve the privacy, safety, human dignity, and the physical and emotional comfort of the inmate at all times.
2. Equipment Maintenance:
  - a. Five point clinical restraints are kept in the infirmary, ~~physical therapy room~~, in a locked shadow box.
  - b. The key to the shadow box is in the Command Post. The key to the restraints are on the restraint bag. Instructions on how to access the shadow box are located on the shadow box.

**IV. Attachments:**

Infirmary Observation and Management Plan	attachment #1
Infirmary Clinical Restraints and Management Plan	attachment #2
Monitoring Checklist for Level 1 or Level 2 Observation	attachment #3
Monitoring Checklist for Clinical Restraints	attachment #4
Emergency Mental Health Evaluation, Suicide Risk Assessment and Treatment Plan	attachment #5

**V. References:**

NCCHS Standard P-I-01, 2014  
NCCHC Standard M-I-01, Restraint and Seclusion, 2015  
NCCHC Standard P-G-03, 2014  
Montana Code Annotated: 53-21-146, 53-21-145, and 53-21-147  
MSP 3.1.8, Use of Force & Restraints

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MSP HS E-09.0, Mental Health Evaluations of Inmates in Segregation  
Montana State Hospital Policy and Procedure: Use of Seclusion and Restraint #TX-16.

**Infirmiry Observation and Management Plan**  
Mental Health Services at Montana State Prison

Inmate Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Housing Unit: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First)

(Check appropriate boxes): ☐ **Admission Orders:** ☐ **Follow-up** ☐ **Discharge**

☐ **Level 1 Observation**

1. Admit to South Isolation Cell 7
2. Mattress
3. Safety blanket
4. Safety gown
5. Nutraloaf
6. No personal property
7. Level of Observation:
  - ☐ Q 15 minute checks via monitor
  - ☐ Q 30 minute checks face-to-face
  - ☐ One on one supervision
  - ☐ Other: \_\_\_\_\_

• **Modifications to Level 1 or Level 2:**

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• **Infirmiry staff- please document the following:**

- ☐ Monitoring checklist for Level 1 or 2 observation ☐ Abnormal behavior(s) ☐ Medication compliance  
☐ Interaction with staff ☐ Response to medication(s) ☐ Evidence of decompensation ☐ Other: \_\_\_\_\_

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☐ **Reason for admission:** • See Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan dated: \_\_\_\_\_.

☐ **Follow-up plan:** • See Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan dated: \_\_\_\_\_.

☐ **Discharge plan:** • See Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan dated: \_\_\_\_\_.

• **Consultation with Infirmiry Staff- Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

• **Mental Health Service Provider:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Staff Signature) (Title) (Date)

## Infirmery Clinical Restraints and Treatment Plan

Mental Health Services at Montana State Prison

Inmate Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Housing Unit: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First)

(Check appropriate boxes):

☐ **Admission Orders:**

☐ **Follow-up**

☐ **Discharge**

**(Full Restraints):** ☐ **5 point Bed** ☐ **Chair**

1. Admit to South Isolation Cell 6 (*or state location below*)
2. Patient to lay on his back (supine) on the stationary bed.
3. Apply both wrist restraints.
4. Apply both ankle restraints.
5. Apply waist restraint.
6. Privacy sheet and pillow.
7. Nutraloaf.
8. No personal property.  
(*may have underwear while in restraint chair*)
9. Level of observation:
  - Constant video observation.
  - Q 15 minute checks face-to-face.
  - One on one supervision.
10. ROM to all extremities q 2 hours.
11. Offer fluids q 2 hours.
12. Offer toilet facilities q hour.
13. Vital signs q 2 hours.
14. Additional orders: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2 or 3 Point Restraints (choose below):**

☐ **2 point restraints:**

- ☐ Both wrists, or
- ☐ Both ankles

☐ **3 point restraints:**

- ☐ Both ankles

1. Admit to South Isolation Cell 6.
2. Patient to lay on his back (supine) on the stationary bed.
3. Privacy sheet and pillow.
4. Nutraloaf.
5. No personal property.
6. Level of observation:
  - Constant video observation
  - Q 15 minute checks face-to-face
  - One on one supervision.
7. ROM to all extremities q 2 hours.
8. Offer fluids q 2 hours.
9. Offer toilet facilities q hour.
10. Vital signs q 2 hours.
11. Additional orders: \_\_\_\_\_  
\_\_\_\_\_

• **Infirmery staff - please document the following:**

- ☐ Monitoring checklist for clinical restraints ☐ Abnormal behavior(s) ☐ Medication compliance
- ☐ Interaction with staff ☐ Response to medication(s) ☐ Evidence of decompensation ☐ All care rendered
- ☐ Other: \_\_\_\_\_

☐ **Reason for admission:** • See Emergency Mental Health Evaluation, Suicide Risk Assessment, and Management Plan dated: \_\_\_\_\_ for restraint justification.

☐ **Follow-up plan:** • See Emergency Mental Health Evaluation, Suicide Risk Assessment, and Management Plan dated: \_\_\_\_\_ for restraint justification.

☐ **Discharge plan:** • See Emergency Mental Health Evaluation, Suicide Risk Assessment, and Management Plan dated: \_\_\_\_\_ for restraint discontinuation.

• **Consultation with Infirmery Staff- Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

• **Mental Health Service Provider:**

\_\_\_\_\_  
(Staff Signature)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

## MONITORING CHECKLIST FOR LEVEL 1 or LEVEL 2 OBSERVATION

TIME	00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45											
BEHAVIORS	0600				0700				0800				0900				1000				1100				1200				1300				1400				1500				1600				1700			
Awake																																																
Asleep																																																
Calm/Quiet																																																
Agitated/Loud																																																
Cooperative																																																
Uncooperative																																																
Education																																																
Record Meals																																																
I/O (if ordered)	I			O	I			O	I			O	I			O	I			O	I			O	I			O	I			O	I			O												
INITIALS																																																

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_

TIME	00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45				00 15 30 45							
BEHAVIORS	1800				1900				2000				2100				2200				2300				2400				0100				0200				0300				0400				0500			
Awake																																																
Asleep																																																
Calm/Quiet																																																
Agitated/Loud																																																
Cooperative																																																
Uncooperative																																																
Education																																																
Record Meals																																																
I/O (if ordered)	I			O	I			O	I			O	I			O	I			O	I			O	I			O	I			O	I			O												
INITIALS																																																

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ / \_\_\_\_\_ Nurse Signature: \_\_\_\_\_ / \_\_\_\_\_

Inmate Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Date: \_\_\_\_\_

## MONITORING CHECKLIST FOR CLINICAL RESTRAINTS

TIME	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45				
<b>RESTRAINTS</b>	0600				0700				0800				0900				1000				1100				1200				1300				1400				1500				1600				1700			
<i><b>Must Check every Fifteen Minutes</b></i>																																																
2 Point																																																
3 Point																																																
5 Point/Chair																																																
Waist																																																
Other																																																
ROM Q2hr while awake																																																
Hygiene 2xday																																																
Fluids Q2hr WA																																																
<b>INITIALS</b>																																																

COMMENTS:

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TIME	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45								
<b>RESTRAINTS</b>	1800				1900				2000				2100				2200				2300				2400				0100				0200				0300				0400				0500			
<i><b>Must Check every Fifteen Minutes</b></i>																																																
2 Point																																																
3 Point																																																
5 Point/Chair																																																
Waist																																																
Other																																																
ROM Q2hr while awake																																																
Hygiene 2xday																																																
Fluids Q2hr WA																																																
<b>INITIALS</b>																																																

COMMENTS:

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Nurse Signature: \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ / \_\_\_\_\_

Inmate Name: \_\_\_\_\_

ID#: \_\_\_\_\_

Date: \_\_\_\_\_



**Emergency Mental Health Evaluation, Suicide Risk Assessment, and Treatment Plan**  
Mental Health Services at Montana State Prison

Inmate Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Housing Unit: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First)

Referral Source: \_\_\_\_\_ Referral Date: \_\_\_\_\_ Referral Time: \_\_\_\_\_

**Type of assessment** (check): ☐ Self-harm act, ☐ Self-harm threat, ☐ Suicide act, ☐ Suicide threat, ☐ Actively psychotic,  
☐ Destructive behavior, ☐ Destruction of property, ☐ Infirmary observation status, ☐ Infirmary clinical restraints, ☐ Other: \_\_\_\_\_

**Suicide Risk Assessment:**

1. Does the inmate have an Axis I or II disorder: ☐ No ☐ Yes, describe: \_\_\_\_\_

2. Does the inmate have a chronic medical condition? ☐ No ☐ Yes, describe: \_\_\_\_\_

3. Has the inmate taken illicit drugs or drank alcohol recently? ☐ No ☐ Yes: \_\_\_\_\_

4. Does the inmate have a history of suicide threats? ☐ No ☐ Yes: \_\_\_\_\_

5. Does the inmate have a history of suicide attempts or gestures: ☐ No history ☐ Recent history (past 12 months), describe: \_\_\_\_\_

• Means for gesture or suicide attempt: \_\_\_\_\_

6. Current suicide ideation:

• Inmate's statement (subjective information): \_\_\_\_\_

☐ None

☐ Passive thought

☐ Active thoughts: Duration \_\_\_\_\_, Frequency \_\_\_\_\_, ☐ Persistent, ☐ Obsessive.

• Able to control suicidal thoughts? ☐ Yes ☐ No

• Has made preparations for death? ☐ Yes ☐ No

7. Suicidal intent: ☐ No current intent (last 24 hours), ☐ No intent but not able to verbalize ability to be safe

• Intent related to: ☐ Wish to die, ☐ Desire to hurt someone, ☐ Need to escape, ☐ Need to punish self

8. Suicidal plan: ☐ No concrete plan, ☐ Plan without means, ☐ Plan with means: \_\_\_\_\_

9. Thoughts regarding their future: ☐ Faith in solutions/resolution, ☐ Indifferent, ambivalent, ☐ No hope

10. Impulsivity: ☐ No elevated risk factors.

☐ Feels compelled and/or driven at times, ☐ Feels a loss of control at times, ☐ Gets involved in fights,

☐ Acts without reflection on consequences, ☐ Has a "bad temper," ☐ Has numerous rule infractions

11. Self-harm: ☐ No history

☐ Has history: \_\_\_\_\_

☐ Has current plan: \_\_\_\_\_

12. Deterrents to suicide: ☐ Loved ones, ☐ Spiritual faith, ☐ Hope for future, ☐ Other: \_\_\_\_\_

13. **Risk Potential:** ☐ No elevation (Denies current suicide ideation, no indicators evident).

☐ Moderate (Suicide ideation without intent).

☐ High (Strong ideation with intent).

**Objective Assessment:** (Inmate's age, mental status, thought process/content, affect, etc.)

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[illegible]

•Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

•Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consultations:** ☐ Consulted with Unit Management Team: \_\_\_\_\_

\_\_\_\_\_

☐ Consulted with Mental Health Staff: \_\_\_\_\_

\_\_\_\_\_

☐ Consulted with Infirmary Staff: \_\_\_\_\_

\_\_\_\_\_

☐ Consulted with other staff, explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Staff Signature) (Title) (Date)